WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Prior Authorization/Physician Otological Report (PA/POR) is required by Wisconsin Medicaid when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the recipient's medical record. Upon completion, give one copy to the recipient to take the testing center and retain a second copy for your files.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s) Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I ? PROVIDER INFORMATION

Element 1 — Name — Physician
Enter the name of the requesting physician.

Element 2 — Physician's UPIN, Medicaid Provider Number, or License Number
Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number, or license number of the physician.

Element 3 — Address — Physician
Enter the address (street, city, state, Zip code) of the requesting physician.

Element 4 — Telephone Number — Physician
Enter the telephone number, including area code, of the requesting physician.

SECTION II ? RECIPIENT INFORMATION

Element 5 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain th correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 7 — Address — Recipient
Enter the complete address (street, city, state, and Zip code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 8 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box.

SECTION III ? DOCUMENTATION

Element 10 — Medical History of Hearing Loss
Enter the recipient's medical history of hearing loss (if any).

Element 11 — Pertinent Otological Findings
Enter an "X" in the appropriate box(es) and describe all problems.

Element 12 — Additional Findings
Describe any additional findings not covered in Element 11.

Element 13 — Clinical Diagnosis of Hearing Status
Enter the diagnosis of the recipient's hearing status.

Element 14 — Medical, Cognitive, or Developmental Problems
Describe any medical, cognitive, or developmental problems of the recipient.

Element 15 — Physician's Recommendations
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.

Signature — Physician and Date Signed
The requesting physician must sign the form and enter the date the request is made.